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COMPLICATED LABOR*
with special reference to the use of forceps

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Abnormal labors present many serious problems, and unfortunately it is not always possible to anticipate complications. In the conduct of every labor two lives must be considered and everything possible done to conduct the delivery in a manner which will mean maximum safety for both mother and infant. Whenever conditions which may be recognized during pregnancy suggest the possibility of an abnormal labor, the patient should be sent to a hospital for delivery. Should bleeding occur a complete blood count, blood typing and preliminary arrangements for transfusion is imperative. Many women lose their lives each year because the responsible physicians have not realized the seriousness of bleeding during pregnancy or labor. All toxic patients should be sent to the hospital for observation and treatment; proper care is not possible in a home.

Cases requiring Cesarean section because a definite disproportion is present do not present a serious problem. Cesarean section is not a difficult operation for the trained obstetrician. However, borderline cases where a test of labor may be needed before deciding for or against Cesarean section, and those in which dystocia results from an abnormal position present real problems for us all. Since most labors progress in a fairly normal manner, it is almost impossible for the average practitioner to acquire in his practice the skill needed for the safe management of a difficult complicated case. Even specialists who have contact with abnormal cases in teaching clinics must practice obstetrics for years before they are able to have contact with a sufficient number of complicated cases to have a reasonable experience. It is estimated that specialists conduct less than 20 per cent of the deliveries in America, the great mass of obstetrical patients being under the care of general practitioners and midwives.

Operative obstetrics for the general practitioner practically is limited to use of the forceps and very rarely a version and extraction. However, such a large experience is needed before one may perform a difficult forceps delivery with a reasonable chance of success, that many hospitals in America and most hospitals abroad no longer permit the average general practitioner to apply forceps to the head which has not reached the perineum. Reports from the hospitals where this rule has been in effect for a number of years show that it has resulted in earlier consultation in the labors which have not progressed normally, with a resulting protection to all and a material reduction in mortality and morbidity. As it is customary for the attending obstetrician to make only a nominal if any charge when called to see a patient in the low income group, the family physician is able to receive the fee he had been promised without hardship to the patient. The application of forceps being the most common obstetric operation it will be given my chief attention both in my discussion and in the movies which follow.

During the years of my practice in Milwaukee, Wisconsin, I delivered 641 babies in private practice by means of forceps applied to the head with a gross loss at birth or during the first thirty days of 11 or 1.75 per cent. In addition, the Piper forceps was applied to the aftercoming head 20 times, with the loss of one premature infant. In the management of 750 normal labors in the same series there was a gross loss of 16 babies or 2.13 per cent.

*Read before the Medical Society of Delaware, Rehoboth, September 11, 1940.

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If we combine all of the forceps deliveries noted above there would be 661, with a gross loss of 12 babies, or 1.81 per cent, a figure which is slightly lower than I was able to obtain in the easier more normal deliveries. In three other cases I attempted to apply the forceps without success and then delivered stillborn infants by version and extraction; adding these, the gross infant loss would be 2.27 per cent, or almost the same as that of the normal labors. My results suggest that an outlet forceps is perhaps the safest method of delivery. The purpose of this paper is to discuss the technic which made it possible to obtain the results which are here reported.

Perhaps certain experienced obstetricians apply the forceps more often than others believe desirable, (41.7% in my private series), but the real abuse of the forceps operation arises not in its frequency but rather in attempts to apply the blades through an undilated cervix or to a head which has not entered the pelvis. Such attempts are always followed by an excessive use of force during the delivery. Certain conditions must be fulfilled before the obstetric forceps may be used with any degree of safety for mother or infant. While these are fully discussed in every obstetric textbook, it is believed advisable to restate them in this discussion.

1. *The cervix must be fully dilated.* In certain cases with an abnormal position of the head, where the cervix may be well effaced but not completely dilated, moderate manual dilatation may be justified if there are adequate reasons for prompt delivery. In an occasional case, where prompt delivery is indicated before dilatation is adequate, vaginal hysterotomy may be necessary.

2. *The membranes must be ruptured.*

3. *The presentation and position must be favorable.* The forceps is not applicable in a shoulder presentation and it is rarely applied to a breech, although very useful in the delivery of the aftercoming head. Version and extraction usually is a better method for delivery of a mento-posterior or a brow posterior, as well as other head presentations if the head becomes impacted at the inlet. However, a manual correction and a high application of the forceps is occasionally possible.

4. *There must not be too much disproportion.* Before attempting a mid- or a high forceps delivery the relative size of the fetal head and the birth canal must be determined as accurately as possible. In border-line cases Roentgen-ray measurements may be very important.

5. *The fetal head must be engaged.* Cesarean section where there is a definite disproportion, or version and extraction if there is no disproportion, have replaced the application of forceps to the floating head. Application of the forceps to a head in a high position may be followed by a relatively easy delivery in a multiparous woman, but it is usually difficult if the patient is a primipara, and is rarely advisable.

6. *The fetus should be alive.* Just as one does not intentionally select Cesarean section for the delivery of a dead fetus, one should avoid a hard forceps delivery if the fetus is dead. However, craniotomy is a repulsive operation even on a dead fetus and the forceps may be used provided the delivery can be accomplished without severe injury to the maternal soft parts.

7. *The rectum and bladder must be empty.*

The proper field for the use of the forceps is during the second stage of labor and in those cases where the head is well engaged or on the perineum. Other conditions being favorable, the forceps may be used to correct an abnormal position of the head as well as to assist the natural forces of labor. In a delayed labor the woman may become exhausted if subjected to a long second stage. The fetus also may be seriously damaged or lost if a long second stage is permitted. Provided conditions for its use are favorable, in case of a delayed labor, the forceps should be applied before the force of labor has endangered either the mother or the infant. This is the proper time for a prophylactic forceps. Certain women have need for an easy delivery because of one or more complications, such as heart disease, tuberculosis, pneumonia, toxemia of pregnancy, or hemorrhage. Changes in the fetal heart rate or a prolapse of the cord may require the use of forceps provided the cervix is dilated and the head engaged.

Preparation of the patient: Both bladder and rectum should be empty. The surgical preparation should be as thorough as for a vaginal hysterectomy. Shaving removes much of the dirt from the external genitalia and more can be removed by means of soap and water. After testing various antiseptics, I have for many years used a four or five per cent aqueous solution of mercurochrome for the final preparation of the vulva and to cleanse the vagina. Cleansing of the vagina is accomplished by means of a ring forceps and small pieces of gauze soaked in the mercurochrome solution. So far as possible, I wait at least five minutes after completing the vaginal preparation before making a vaginal examination or applying the forceps. While waiting the bladder should be emptied by means of a soft rubber catheter of a fairly large size.

Forty-three of the 641 women delivered with forceps showed a "temperature morbidity," based on a temperature of 100 degrees on two or more days during the puerperium, a morbidity rate of 6.7 per cent. However, if the forceps cases are separated into groups according to the types of vaginal preparation, it is found that prior to the use of mercurochrome in vaginal preparation, there was a "temperature morbidity" of 10.6 per cent, while in a much larger group in which mercurochrome was used in the vagina the rate was 5.7 per cent. In the last 100 forceps deliveries in this series only two women had a temperature of 100 degrees on two or more days, and one of these had a respiratory infection and a temperature of 101.5 degrees at the time of delivery. The favorable morbidity in the last 100 cases probably was due in part to the avoidance of vaginal packs during the repair of the perineum. Episiotomy was almost a routine procedure for all women who had a good perineum. My results indicate that the careful use of the obstetric forceps does not increase maternal morbidity as evidenced by a temperature during the puerperium.

Choice of forceps varies greatly in practice. The Tarnier forceps was designed for compression and it is not a safe instrument. I have several instruments, but prefer Webster's modification of the Milne Murray axis traction forceps since it may be used for all types of cases. It is easier to train students to use an instrument of this type than to teach them how to perform properly Pajot's maneuver. With the English, I believe that the physician who has one forceps should have a good axis-traction instrument, but not the Tarnier.

Application of the forceps blades should be to the sides of the head if possible. This necessitates an accurate diagnosis of position. The indication for the use of forceps may be an abnormal position of the head and a proper application will depend upon one's ability to correct the position manually with the fingers or with the first blade of the forceps and the fingers. Great care is required in attempting manipulations of this type since one may cause serious head injuries through the use of force in an attempt to correct an unfavorable position. Introduction of all four fingers into the vagina lessens the risk of contamination from the anus. After the blades have been applied one should determine through further examination that the application is proper before making traction.

All statements regarding the use of forceps thus far made conform closely to usual textbook teaching. Perhaps my only contribution to the safety of this operation has been in showing that it can be accomplished with less danger to the fetus through the use of intermittent nitrous oxid-oxygen analgesia. While discussing a paper on analgesia and anesthesia in labor, before the American Gynecological Society in 1920, I made the following statement:

"Recently I have been using nitrous oxid-oxygen analgesia intermittently for mid- and low-forceps deliveries as well as in normal labor. The nitrous oxid-oxygen is given to a deep analgesia or light anesthesia while the forceps is applied. The mask is then removed, and thereafter the gas administered intermittently as in normal labor. The patient is instructed to bear down during contractions, while *gentle traction* is made on the forceps."

During the past twenty years I have used the intermittent gas-oxygen analgesia for all types of forceps deliveries, and I attribute the

very low fetal loss in the series reported in this paper to the fact that the forceps have been used *to assist the forces of natural labor rather than as a substitute for the natural forces.* This technic probably makes little difference when doing a perineal forceps but it is believed to be of major importance in the more difficult cases. My results in forceps deliveries are shown in the following table:

FORCEPS DELIVERIES, VERTEX PRESENTATIONS

28 high forceps .....gross infant loss 2, or 7.0%
326 mid-forceps .....gross infant loss 8, or 2.4%
287 low-forceps .....gross infant loss 1, or 0.35%

Infant loss includes stillbirths and deaths during first thirty days.

One mother died in convulsions and one died from influenzal pneumonia.

Medical Arts Building

MEDICAL PREPAREDNESS— HOW IT IS TO WORK

On September 20, 1940, a conference was held in Chicago at the American Medical Association headquarters on the subject of medical preparedness. Those attending the conference were the Committee on Medical Preparedness of the American Medical Association, state chairman or representatives from every state in the union but one, representatives from the office of the Surgeon Generals of the Army and Navy, and Surgeon General Parran of the United States Public Health Service. Colonel Spruit and Colonel Love of the Army, and Captain Dutton of the Navy, spoke to the group and answered the many questions which arose. From this conference, your state chairman on medical preparedness brings back to you the following information which, for the sake of convenience, will be divided into sections.

I. FIRST PHASE OF PROGRAM

A. Local draft boards will be set up in each county, each with an examining physician attached. In more populous counties there will be more than one board. Ten counties in Iowa have two boards; two counties have three boards; and one county has seven.

B. Each draft board will have an examining physician.

1. *How is the examining physician chosen?* Each county medical society has been asked to recommend two physicians (for each draft board) who are over thirty-five years of age, citizens, and not a member of the National Guard or any reserve corps. These names are sent to the Iowa State Medical Society and submitted to the Governor through the office of the Adjutant General; the Governor selects one of the two for each board; the President of the United States then appoints the physician so chosen.

2. *What are the duties of the examining physician?* He shall examine all men who have been certified by the local draft board as eligible for service. The board will pass upon exemptions and deferments; the physician will have to examine only those men who are placed in Class I. Complete instructions and standards for the examination will be supplied by the War Department.

3. *What are the responsibilities of the examining physician?* He will report his findings and make his recommendation to the local draft board. The draft board makes the final decision as to whether the man shall or shall not serve. The responsibility for rejecting or accepting him does not rest with the examining physician.

4. *Will the examining physician have any assistance?* Yes, if he wishes, he may ask assistance from the Medical Advisory Board which will be set up in his district. (This board is explained more fully in the second phase of the program.) He may also ask the local draft board for additional physicians to help him if he thinks it necessary.

5. *How many men will have to be examined by the physician?* The present plan calling for 40,000 men means that each draft board will pass approximately ninety men. These will be seen over a period of about three months, so that the physician will have to examine between 20 and 30 men each month, according to present figures.

6. *What compensation will examining physician receive?* It was the feeling of those present at the Chicago meeting that the local draft boards and examining physicians should not be paid for their services but should make them their patriotic contribution to the government. The draftee who is called into service is the one who makes a real sacrifice. Those who are not called may wish to do their part at home, and this offers them an oppor-

tunity to do so. Only clerical help will be paid. Every effort will be made to keep the program from becoming a job-holding organization.

7. *What recognition will be given to the examining physician?* The Committee on Medical Preparedness will devise some sort of badge and certificate which will be given by the President of the United States to all physicians who serve their country in this manner.

II. Second Phase of Program

A. Board of Appeal. A Board of Appeal will be established in each county or district, to act upon appeals from the decision of the local draft board. It shall be composed of local non-medical civilians.

B. Medical Advisory Board. A medical advisory board has been suggested for each Councilor District in the state of Iowa.

1. *How are these Boards chosen?* Your State Committee on Medical Preparedness made recommendations concerning the personnel of these boards and submitted them to the Governor through the office of the Adjutant General. He will select one physician of each specialty and that physician will be appointed by the President.

2. *What is the composition of these Boards?* They consist of an internist, a surgeon, an ophthalmologist, a psychiatrist, a dentist, a chiropodist, an orthopedist, and a radiologist.

3. *What are the duties of these Boards?* They will assist the examining physician whenever he calls upon them for help in making a recommendation; they will examine registrants upon request of the local draft board; and they will examine registrants upon request by the board of appeal. They are to aid the three groups named above whenever called upon to do so.

4. *What are their responsibilities?* They examine the registrant and report their findings and recommendations to whichever group has requested their assistance. They do not pass judgment nor make the decision as to whether the man shall or shall not serve.

5. *Will the members of these Boards be paid?* No, they too will serve without compensation, for the same reason as that given for the examining physician.

6. *What recognition will be given to these physicians?* They will be given a badge and certificate by the President of the United States for their contribution to the defense of the country.

The first and second phases of the program are local in character, and are performed by volunteer civilians and physicians. The third phase is under the control of the War Department and we cannot speak fully at the present time of what its procedures will be. After the draftee has been passed by the examining physician and the local draft board, he appears before the Army Induction Board. These boards will be decentralized so that the draftees will not have to travel as far from home as in the last war. There will be at least one in every state, and more in most states. The personnel of these boards will be military officers for the most part. They are not local boards, but are Army boards. Some physicians will be members of these boards. Present requirements are that they include three internists, one surgeon, one orthopedist, two ophthalmologists, one otolaryngologist, one neuropsychiatrist, one clinical pathologist, and one dentist. Medical Reserve officers will be used on these boards whenever possible, but it may be necessary to hire civilian specialists to help. Such civilian specialists will be paid for their time, and the American Medical Association, through its Committee on Medical Preparedness, has been asked to make recommendations as to a fair compensation.

What is the status of Reserve Officers? Medical Reserve officers are subject to call, just as are other reserve officers, and may be required to serve one year. Exemptions and deferments will be granted individually, according to the circumstances. Such officers do not have to register October 16, however.

What is the status of physicians eligible for conscription because of age? All physicians who are within the age limitations of the draft who are not reserve officers or members of the National Guard, must register and will be subject to call. They may, however,

apply now for a commission in the reserve corps, and the question of service will be determined by the War Department. It was recommended that all eligible physicians do this at once, since it would assure them higher rank and compensation, but not make service mandatory at once. If this is not done, the physicians' names will be subject to the general draft lottery. If he is drawn into service, he may apply for a commission and obtain it at that time, although this is not certain.

What is the status of internes, residents and students? Internes will be allowed to finish their year's work before being called into service. It was suggested that they be urged to apply for commissions in the reserve corps, so that they might complete their course of training. It is possible that residents may be exempted, but the feeling seemed to be that they could be spared from hospitals more easily than internes. Students will be allowed to finish their year of school and will not be called until July 1, 1941. Junior and senior medical students who are officers in the R. O. T. C. will not be conscripted. Sophomore students who become officers in the R. O. T. C. at the end of their sophomore year, or before July 1, 1941, will thus become exempt. Freshman medical students seem to be the only ones who may be affected by the draft.

What is the relation of the American Medical Association questionnaire to conscription? Since the conscription bill will affect all physicians under thirty-six years of age, we assume that the survey being made by the American Medical Association will be most useful in supplying information regarding physicians who are over thirty-five years of age. In all probability the War Department will call upon the Association for the names of specialists in different communities, and possibly for names of doctors who have signified their willingness to serve in some military capacity.

How can the practice of a physician doing military service be protected? The answer to this problem lies in the humanity and morality of his colleagues. No Federal regulation can solve it. In the smaller communities, the doctors who remain at home may agree to care for his patients and turn the fees over to his family, and deliver his patients to him on his return from service. This is being done in many small communities. In larger communities, the problem is more complicated. The five counties comprising Greater New York have set up a fund. When a doctor leaves for service, he notifies his county society that he is going. The other doctors then take care of his patients and turn the fees in to this fund. They are allowed a small percentage of the fee in some instances for their overhead, but it would not exceed five per cent. The money accumulated in the fund is paid to the physician or his family, as he may direct. This is a realistic approach to solution of the problem.

What is the function of the county medical society in medical preparedness? Every county medical society has been asked to appoint a Committee on Medical Preparedness. This committee could and should survey the medical resources of the county, and make a confidential report to the draft board as to which physicians cannot be spared from the community without endangering its health. It should also be responsible for protecting the practice of the physician who is called for service. An active committee can do much to safeguard the interests not only of the civilian population, but also of the doctor who is called into service, and the defense program as well.

J. Iowa S. M. S., October, 1940.

DELAWARE ACADEMY OF MEDICINE

An interesting addition, lately received at the Academy, to the collection of items which have belonged to Delaware doctors is a brass mortar and pestle, on which is inscribed:

Used By

WILLIAM TILDEN SKINNER, M. D.
1842-1906

Practiced At Glasgow, Delaware
1870-1906

President of the Medical Society of Delaware
1888-1889

Presented by His Daughter,
Anne C. Skinner

At The

Sesqui-Centennial of The Society
October 9-11, 1939

For a photograph and biography of Doctor Skinner, who was the Society's centennial president, see:

One Hundred and Fiftieth Annual Session of the Medical Society of Delaware, 1789-1939, October 9, 10, 11, 1939, p. 87-93, published by the Society.

The Academy needs more members in order to carry on the splendid work it is doing. A recent checkup shows that 15 per cent of the dentists and 37 per cent of the doctors of the state are members. This is a creditable showing for a young institution, but the figures should be doubled if the Academy is to achieve its purpose.

DOCTORS AT WORK

Doctors at Work is the title of the sixth annual series of dramatized radio programs to be presented by the American Medical Association and the National Broadcasting Company.

The series will open Wednesday, November 13, 1940, and run for thirty consecutive weeks, closing with a broadcast from the A. M. A. meeting at Cleveland, on June 3, 1941. The program is scheduled for 10:30 p. m. Eastern Standard Time (9:30 Central; 8:30 Mountain; 7:30 Pacific time) over the Blue network, other NBC stations and Canadian stations.

The programs will dramatize what modern medicine offers the individual in the way of opportunities for better health and the more successful treatment of disease. Incidental to this main theme, the programs will explain the characteristics of the different fields of modern medicine and its specialties.

Doctors at Work will be broadcast from scripts by William J. Murphy, NBC script writer and author of many previous AMA-NBC "shows" and other popular radio features. It will be produced under the direction of J. Clinton Stanley, director of Medicine in the News, last season's successful AMA-NBC health program. Supervision will be by the AMA Bureau of Health Education, directed by W. W. Bauer, M. D.

Descriptive posters for local distribution may be had gratis from the Bureau of Health Education, American Medical Association, 535 N. Dearborn St., Chicago. Program titles will be announced weekly in The Journal of the AMA and monthly in Hygeia, the Health Magazine.

IS IT A GAME?

The shortening of the days and the turning of the leaves herald the approach of another football season. Whether this is eagerly anticipated or viewed with alarm depends on one's opinion concerning the benefits of this form of athletic contest. Modern football demands of the player a splendid discipline, self-control and a subordination of the individual to the team. Today is might well be given a place in the list of those character-building activities William James suggested in his essay, "The Moral Equivalent of War." Whether these good qualities outweigh the evils of "overemphasis" and "a game for gate receipts only" is debatable. Without taking sides on this point, it cannot be denied that there are few universities, colleges or even schools which have not been accused of professionalism in football to a greater or less degree.

The element of serious injury to the player is far less of a problem today than it has been in the past. However, as is pointed out in an article in this issue of the *Journal*, safety for the player is apparently to be obtained only with careful supervision by a competent personnel. The author quotes figures that seem to show that the danger of serious injury in this sport is at a minimum only when there is adequate medical supervision and when the rules are enforced by competent officials. He very properly states that it is in the unsupervised games that serious injury is most likely to occur, and also suggests that his figures show that serious injuries can be prevented under nearly ideal conditions. Such conditions, however, are not obtained in a large percentage of cases. As long as the colleges

play football the schools will probably do likewise, as will the groups of sand-lot players.

There is one aspect of this question that is seldom referred to, although it has an important bearing on the large number of seriously crippling joint injuries. Thirteen to seventeen years cover the ages of most schoolboy and "sand-lot" participants of this game. For many boys this is a period of rapid skeletal growth, and their muscular and ligamentous strength does not always keep pace with their bony growth. "Their legs are long and their joints are loose," they are clumsy, and they do not co-ordinate well. To subject them to the danger of joint injury during an age when their joints lack the normal muscular and ligamentous support that will come a year or two later is to court disaster. Knee injuries at this age may, and often do, result in a joint that is never again able to stand the stress of even ordinary sports. It is probable that the number of boys incapacitated for college football because of knee injuries sustained in secondary schools is far larger than is shown by any available statistical data. And it is not only at the schools with inadequate medical supervision that such accidents occur.

The professional athlete appreciates that he is only as strong as his legs, and he spends many hours of drudgery on "road work." The average schoolboy concentrates on a beautifully developed torso and arms. With walking now reduced to a minimum, a pair of sturdy legs and knees is far less common than it was in the days before the automobile.

If schoolboy football is to be reasonably safe only when medical supervision of the elaborate and expensive type advocated in this article is furnished for all participants of all ages, one might well ask, Is it worth while? and, Is it a game?

Editorial, New England J. M., Sept. 26, 1940.

ONE THIRD OF ARMY APPLICANTS REJECTED FOR PHYSICAL REASONS

Of 6,743 applicants for enlistment in the Regular Army during June, July and August, 1940 in the Southern New York District of the Second Corps Area, which includes New York City proper, 2,195 or more than 32.5 per cent were rejected for failure to meet the Army's physical requirements, George E. Leone, M. D., captain of the Medical Corps of the U. S. Army and medical inspector for recruiting of the Second Corps Area, New York, reports in *The Journal of the American Medical Association* for Oct. 12.

The major causes for rejection of these men, who had the other required Army qualifications, were teeth, eyes, height and weight (stature), feet and ears in that respective order, Captain Leone says.

The report is of value, he says, in giving medical examiners a clue as to what to look for particularly in the examination of applicants. "It is also hoped that some preventive and remediable measures may be instituted for the better preservation of the health of the youth of our nation," he points out.

In commenting on the importance of the various physical standards for entrance into the Army, Captain Leone says: "There were 516 rejections due to teeth, more than 23 per cent of the total number rejected. It is well known that the condition of the teeth is a fairly reliable criterion of the general health and habits of young men. The minimum requirements consist of a total of six masticating teeth and six incisor teeth. All these teeth must be so opposed as to serve the purpose of incision and mastication.

"The next in importance was the failure to meet the requirements in vision; 21 per cent of the total number rejected were in this group. Most of these young men who could not see well enough to become soldiers did not wear glasses. Practically all of them had been driving motor vehicles and many could not be made to understand why they should be rejected, as they possessed operators' permits to drive. Had many of these men been equipped with the proper correctable lenses they would have met the requirements.

"A total of 213, or little more than 10 per cent, were rejected because of poor feet.

"There were 202, or 10 per cent, in the group rejected for failure to meet the hearing and ear requirements. The majority of those rejected in this group were found to be suffering from purulent otitis media (inflammation of the middle ear) in acute or chronic form in one or both ears associated with impaired hearing."

EDITORIAL

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Local news of possible interest to the medical profession, notes on removals, changes in address, births, deaths and weddings will be gratefully received.

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The Choice

The Delaware State Medical Journal has never been political. Only once in the nearly twenty-five years tenure of the present editor has the charge of "politics" been leveled at this mouthpiece of organized medicine. On that occasion, at the very beginning of the governmental attacks on the medical profession, we had reprinted an editorial from another state medical journal which roundly, and soundly, exposed the sham and hypocrisy behind the government's maneuvers, and predicted that further and more drastic measures were in the making. How prophetic! Our reply to this one lone complainant was that this Journal was not then and never would be playing politics; but it would *always* fight against unwarranted assaults upon the medical profession, and that we were only beginning a battle for the preservation of the private practice of medicine; we further advised that the only reason we had printed that editorial instead of our own was because the other editor had done it first and better. Such is not politics: it is just plain self-defense.

Now—today—facing the most critical phase of that battle, the doctors of this nation must make up their minds whether they will support at the polls a regime that, step by step, is making a squeeze play against their profession; or whether, forgetting all previous partisan ties, they will support a candidate who has pledged himself for the preservation of private practice. With many the issue is clearcut; it is party vs. profession. In such a situation there can be but one answer from every loyal member of the profession. Let there be no medical fifth column to sabotage and sink their own craft! Everywhere in America today the watchword is national unity for the defense of the American way of life; everywhere in American medicine the watchword is professional unity for the defense of the American way of practice. Such, again, is not politics: it is just plain self-defense. It is the Preservation of the Private Practice of Medicine!

The Election

As the first Tuesday of November approaches it is important that physicians appreciate that the Wagner Health Bill is not dead. Those who favor socialization of the medical profession merely await an opportunity to push this bill through as an emergency measure at a time when everyone is greatly concerned with our effort to strengthen our defenses. Appreciating this danger a committee of physicians with headquarters in Chicago is mailing the following letter to the physicians of America:

"The time has come for the physicians of this country really to do something. If we

refuse or fail to take advantage of the present opportunity we should quit talking and begin preparing to take orders from ward committeemen, precinct captains or political henchmen.

"On November 5th the people of the United States will elect a President. The election has little to do with political parties, Democrat or Republican. The issues are clearly drawn.

"One of the candidates, Mr. Roosevelt, stands for a continuation and extension of centralization of power and authority; the breaking of the third term tradition; and, incidentally, the regimentation of the medical profession.

"The other candidate, Mr. Willkie, stands for the reestablishment of Free Enterprise and equal opportunity, the American way of life; for efficiency and effectiveness in providing an adequate national defense; and, incidentally, for maintaining the pattern of a free and independent medical profession.

"In this great crises it is not sufficient for us merely to vote for the candidate of our choice. Every medical man and woman must take advantage of every opportunity—create opportunity—to talk to friends, patients, nurses and hospital employees with whom they come in contact—to the end that Wendell Willkie shall be elected as the next President of the United States.

"The alternate is a speeded up continuation of the trend toward the centralization of power and the regimentation of the doctors of this country."

The socialized medicine of various European countries has not improved medical care in those countries, and nowhere is it equal to our present medical care. We appreciate that physicians everywhere must continue to work for further improvements. Success will depend to a great degree on a strengthening of our present weak economic structure. It is evident that this must be accomplished through greater individual effort—not by a further increase of power in Washington.

The platform of the American Medical Association for the betterment of medical care is as follows:

THE PLATFORM OF THE AMERICAN MEDICAL ASSOCIATION

The American Medical Association advocates:

1. The establishment of an agency of the federal government under which shall be coordinated and administered all medical and health functions of the federal government exclusive of those of the Army and Navy.

2. The allotment of such funds as the Congress may make available to any state in actual need, for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.

7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.

8. Expansion of public health and medical services consistent with the American system of democracy.

"There is no one to whom socialized medicine is more repugnant than it is to me. I believe in the skill that is developed by the competitive system."—Wendell L. Willkie, Kansas City, Mo., Sept. 16, 1940.

CARL HENRY DAVIS, M. D.

VIEWS OF THE PRESIDENTIAL CANDIDATES*

Mr. Willkie

WENDELL L. WILLKIE
109 East 42nd Street
New York City
Colorado Springs

August 7, 1940.

My Dear Doctor—

You have asked my views on socialized medicine. I am against it. You can quote me any place on this.

Cordially yours,
WENDELL L. WILLKIE.

Dr. T. Leon Howard
Denver, Colorado.

President Roosevelt

THE WHITE HOUSE
Washington

September 6, 1940.

Dear Mr. Sethman:

This acknowledges your letter of August twenty-second with enclosure. The President's views on the subject about which you inquire were expressed in a speech delivered at the Jersey City Medical Center, Jersey City, New Jersey, on October 2, 1936, and, for your information, I have much pleasure in enclosing a copy of that speech. The views expressed by the President on that occasion have in no wise been changed or modified since the delivery of the speech in question and still constitute a complete statement of his principles.

(Signed) STEPHEN EARLY,
Secretary to the President.

ADDRESS OF THE PRESIDENT OCT. 2, 1936

"It is a privilege to take part in the dedication of this Medical Center—the third largest Medical institutional group in the United States.

"I am happy, too, that the Federal Government through its Public Works expenditures, has been able to be of assistance to the municipal government of Jersey City and to Hudson County in making this Center possible. As a matter of fact, the expenditures through the Public Works Administration are increasing the capacity of American Hospitals by nearly 50,000 beds. During the depression the difficulty of obtaining funds through municipal or private sources would have meant a serious shortage in caring for patients and in giving them adequate facilities had it not been for Federal assistance through loans and grants.

"But there is another reason for increasing the bed capacity of the hospitals of the country. The Medical and Nursing professions are right in telling us that we must do more to help the small income families in times of sickness.

"Let me with great sincerity give the praise which is due to the Doctors of the Nation for all that they have done during the depression, often at great sacrifice, in maintaining the standards of care for the sick and in devoting themselves without reservation to the high ideals of their profession.

"The Medical profession can rest assured that the Federal Administration contemplates no action detrimental to their interests. The action taken in the field of health as shown by the provisions of the splendid Social Security Act recently enacted is clear.

"There are four provisions in the Social Security Act which deal with health; and these provisions received the support of outstanding Doctors during the hearings before Congress. The American Medical Association, the American Public Health Association and the State and Territorial Health Officers Conference came out in full support of the public health provisions. The American Child Health Association and the Child Welfare League endorsed the maternal and child health provisions.

"This in itself assures that the health plans will be carried out in a manner compatible with our traditional social and political institutions. Let me make that point very clear. All States and Territories are now cooperating with the Public Health Service. All States except one are cooperating in maternal and child health service; all States but ten in service to crippled children and all States but nine in Child Welfare.

"Public support is behind this program. But let me stress, in addition, that the Act contains every precaution for insuring the continued support and cooperation of the Medical profession.

"In the actual administration of the Social Security Act we count on the cooperation in the future, as hitherto, of the whole of the Medical profession throughout the country. The overwhelming majority of the Doctors of the Nation want medicine kept out of politics. On occasions in the past attempts have been made to put medicine into politics. Such attempts have always failed and always will fail.

"Government, State and National, will call upon the Doctors of the Nation for their advice in the days to come.

"It is many long years ago that Mayor Hague and I discovered a common interest in the cause of the crippled child. This great Medical Center is, I know, close to his heart. I congratulate him on the fulfillment of a splendid dream. I congratulate Jersey City and Hudson County on modern facilities surpassed by no other community in America."

Rocky Mountain M. J., October, 1940.

* Rocky Mountain Med. Jour., October, 1940.

ANOTHER WASHINGTON SMEAR

No better sample of the kind of propaganda our present Federal government is ladling out to our people, in behalf of their program for medical control, could be formed than the broadcast which follows. The inference is given that the cases listed are common and usual; the slur is given that the medical profession, except in only a few large cities, is inefficient or ignorant; the hint is given that diagnostic and treatment facilities are scarce to a shocking degree. None of these inneudos are true. Comment is really superfluous—READ IT FOR YOURSELF—EVERY WORD OF IT.

UNITED STATES
DEPARTMENT OF THE INTERIOR
Division of Information
Radio Section

109713
WJZ and Blue
8:00—8:30 P. M., EDST
August 21, 1940

"THIS, OUR AMERICA"
Program 8
"HEALTH AND EDUCATION"*

ANNOUNCER: As the nation turns to its defense, the National Broadcasting Company in cooperation with the National Resources Planning Board presents the eighth program in the series, THIS, OUR AMERICA, in order that you and I may know exactly what resources we have in order to defend our shores.

2ND ANNOUNCER: Tonight, THIS, OUR AMERICA tells you where we stand in regard to:

VOICE: Education and health in America!

MUSIC: SNEAK UNDER.

NARRATOR: Since Thomas Jefferson, America has wished to provide a free and progressive education for every person in the land. It is a far cry from the little red school house of seventy-five years ago to the quarter of a million elementary schools and the 29,000 high schools—

JOE: (Interrupting) Hello, remember me? Joe, the average guy?

2ND NARRATOR: Glad to see you here again, Joe!

JOE: I know I interrupted you fellows, but I just had to. You were going to tell us the number of schools and colleges and the number of pupils and the number of teachers?

2ND NARRATOR: Yes, we were.

JOE: But we know we got a lot of schools. And we've never complained about paying taxes for them so that our kids could get a decent education. Yeah, we know all that. But—

1ST NARRATOR: But what, Joe?

JOE: I've been doing some thinking about what it means to be educated in 1940. I'd like to shoot off my mouth about it.

2ND NARRATOR: This is your program, Joe—not ours. Go ahead.

JOE: Well, if I had a kid what would I like to have him taught besides the regular things all kids are taught in school? It seems to me three things have to be taught—it seems to me they're more important than anything else right now.

2ND NARRATOR: What are they, Joe?

JOE: First, I keep asking myself: Are the kids in school, are the boys and girls in college—are they being taught to *think?*

NARRATOR: What do you mean, Joe?—think?

JOE: Well, you pick up a half a dozen papers—you can get a half a dozen points of view about anything happening today—you listen to the radio—one guy savs one thing, one guy says another—or take short wave—one side tells you they're right—the other side tells you the opposite. All the education in the world isn't going to do any good unless a fellow can take all these points of view and-and iron 'em out in his mind—and-and know propaganda from the real McCoy—unless he can find the facts and come to his own opinion first hand. That's my idea of what I'd teach my students if I were a teacher.

2ND NARRATOR: Joe, what you're asking for is to teach—judgment?

JOE: That's it! Judgment! Otherwise, anybody can come along and fill us with a bunch of half-baked notions and we accept them . . . and haven't any minds of our own. Well, you're the boys with the facts. Tell me, are the young folks—the ones who'll have to do the work and the fighting to defend us—are they being taught to judge for themselves in this cockeyed world?

NARRATOR: Yes, Joe—

JOE: How?

NARRATOR: All sorts of ways, Joe. By discussion groups, by debates, by forums, and by courses especially designed to make people form individual judgments.

JOE: OK then.

2ND NARRATOR: Go on, Joe. What's the next thing you think makes for a real education?

JOE: Well, a fellow's got to be taught *what* he's defending. Dates in history classes are ok by me; who was Pocahontas and what famous words did Nathan Hale say, that's ok, too. But more than that, kids should be taught *what* it means to be an American. They ought to be taught how words like freedom and liberty are more than just high-sounding words; kids ought to be taught *what* in their own lives, from the time they brush their teeth in the morning till the time they say their prayers at night, brings them this freedom. Well,—are our educators teaching them *what* we are defending?

NARRATOR: Yes, Joe. I think so . . .

JOE: How?

NARRATOR: All over the country, Joe, teachers are putting more emphasis on what America *means* than on what America has *done* historically in the past. Students are taught today exactly what the Constitution means—the right to choose your own representatives and your own Senators and your President; the right to speak freely and the right to print your ideas and the right to worship as you see fit. Educators realize today that a student must be taught what security means, security to work, to be healthy, to live a better life in every way. That's how students are being taught what they're defending.

JOE: That's swell!

2ND NARRATOR: Go on, Joe. What's next on your little list?

JOE: Well, we're going to need a lot of industrial workers—

NARRATOR: I see what you're driving at, Joe. Vocational training?

JOE: Yeah.

2ND NARRATOR: The President has given Mr. Hillman of the Defense Commission the job of seeing to it that young men and women are trained to become skilled workers in many fields. All over the country new vocational schools are being opened to teach crafts to thousands of enrollees. We're making great progress.

JOE: Well, then, I'm satisfied. Only there's one thing more that I think educators ought to be doing.

NARRATOR: What's that, Joe?

JOE: Well, we got to lead the world in Science. We got to know how to make the finest machines for defense. And we got to use Science so that after this defense program is over, we can go on living better—better homes, better soil, better food—better everything in America. That means we got to have men who know about—well, about complicated things—like trade—and—and—economics—and giving everyone a break. That means we got to have our colleges educate men to become leaders, doesn't it?

2ND NARRATOR: Well, 98 thousand college teachers in this country—and that's an awful lot of college teachers, Joe—have just those things as their aim.

* Wisc. Med. Jour., October, 1940.

JOE: Then I feel ok! If a guy is taught to think clearly, to think for himself; if he's taught what he's defending; if he wants to work in industry to help defense and and there are schools to teach him how to work; and if colleges educate men to be leaders of the people —that's what education means to me in 1940!

NARRATOR: And to all of us, Joe. And that's just what we're doing.

JOE: (With an amused sigh) Gosh, I've certainly been talking a lot. . . .

2ND NARRATOR: Then suppose we talk about *you*, Joe.

JOE: Me? Say, you're wasting good radio time talking about me. I'm just a minnow in the pond. What's important is what resources and how many resources this country needs—

NARRATOR: We know all that, Joe. But no resource is as important as you.

JOE: I don't get you.

NARRATOR: You're the greatest single resource in America. You're a living human being. You think the thoughts, you dream the dreams, you put them into effect. You *are* America—132 million Joes.

JOE: Say, I guess you got something there. . . .

2ND NARRATOR: You bet we have! And since you're the greatest single resource of America, it's vital that you learn how healthy you are.

JOE: Me? I'm in fine shape.

NARRATOR: But how about the other Joes in the country? Total defense depends on men like you. The men and the women who work in the fields and in the factories; the men in the Army and the Navy?

JOE: Then let's have the lowdown. Where do we stand on health?

NARRATOR: Part of the story, Joe, isn't pretty. Suppose we tell you the bright side first.

MUSIC: SNEAK UNDER.

NARRATOR: In the last fifty years, we have made amazing gains!

VOICE: Yellow fever has been completely wiped out. . . .

2ND VOICE: The plague has been completely wiped out. . . .

3RD VOICE: Not so long ago, tuberculosis was the fourth most deadly disease in the United States. Today it has dropped to seventh place. Even in the past year this disease has declined almost five per cent.

4TH VOICE: There has been an amazing decrease in the number of infant deaths.

VOICE: Today scarlet fever and diphtheria, malaria and pellagra, typhoid and infantile paralysis are the lowest on record.

2ND VOICE: Our death rate is progressively lower each year. And less people died in the United States in 1938 than in any year before.

3RD VOICE: We have the greatest hospitals in the world. Institutions like Johns Hopkins, the Mayo Institute, the Presbyterian, Belleview, Trudo Sanitorium, the Massachusetts General Hospital are without peer in the world.

4TH VOICE: There are almost 170,000 physicians in the United States. There are over 200,000 nurses in the United States.

VOICE: Every year five thousand young men and women take the oath of Hippocrates to save the lives of their fellow Americans.

2ND VOICE: With all these doctors, nurses, hospitals, and with such medical inventions and discoveries as sulfanilamide—the iron lung—vitamin concentrations—the bronchoscope—there is no reason why America should not become the healthiest nation on the face of the earth!

NARRATOR: Sounds good, doesn't it, Joe?

JOE: I'll say! But let's have the catch to it—

2ND NARRATOR: What do you mean, Joe?

JOE: I know you boys by now. You don't pull any punches. Where's the rub?

2ND NARRATOR: Joe, if these were normal times we live in, we could take up our health problems one by one and over the next twenty-five years solve most of them. But these are not normal times. Just as we are doubling and tripling our industrial expansion, and rushing our plans for armaments, so we must double and triple our fight for life. We can't afford to wait twenty-five years to solve these problems.

JOE: What problems?

NARRATOR: Well, here's one: Each year one million Americans die who could be saved.

JOE: No!

MRS. WILLIS: (Listlessly) Yes, Joe. What this gentleman just said is right.

2ND NARRATOR: Hello, Mrs. Willis. Glad you could come.

MRS. WILLIS: (She has a slight southern accent. Her voice is middle-aged) I want the folks out there to know. I think they have a right to know.

NARRATOR: Suppose you tell your story, Mrs. Willis.

MRS. WILLIS: Henry—he was my husband—Henry and I lived in the South. We lived in a little frame house; had a few chickens; a little truck garden. Henry didn't make much money. Three years ago he took sick, real bad. He'd walk around, all twisted with pain.

2ND NARRATOR: Were there doctors in your neighborhood?

MRS. WILLIS: There were doctors. Henry went to every doctor in the county. He couldn't blame the doctors. The doctors didn't make much more money than Henry did. They didn't have all those expensive machines to tell what ails a person. But they all looked at him and said it was his liver. They used to give him medicines until our bathroom shelf was just piled with medicine bottles. But it didn't help Henry. The pain got worse. He took to bed. Finally he couldn't stand the pain. We didn't have no car and I knew that I should have taken him to a hospital long before this—a big hospital where they had those expensive machines and real big doctors they call—

NARRATOR: Specialists.

MRS. WILLIS: Yes, specialists. But the nearest real big hospital was three hundred miles away. We didn't have the money to get him there.

JOE: Wait a minute. You mean to say the nearest hospital was three hundred miles away?

MRS. WILLIS: Yes, young man. When Henry took to bed and was yelling with pain, I got really scared and I called in my neighbor. He was an undertaker, Jim was. I asked him to drive Henry up to this big hospital in his—in his—(takes a deep breath for control) That was the only way to get him there—Henry lay down in it all the way to the hospital—When we got to the hospital, Jim and me sat in the waiting room while they examined Henry. We waited a long time—

NARRATOR: What did they tell you?

MRS. WILLIS: They didn't say at first. They asked me how long Henry'd been like this. And I said three years. And they asked me why we brought Henry to the hospital only now after three years. I told them how we didn't have

any hospital where we come from. I told them how Henry used to sometimes walk three miles to the nearest doctor and no doctor knew what ailed him. Then the doctor told me what was the matter with Henry. He said it was—cancer.

JOE: Gosh... That's tough!...

MRS. WILLIS: Yes, young man. And they couldn't do anything for him now. The doctors said we'd brought him here two years too late. They said that two years ago had there been a hospital close to where we come from, he might have been cured . . . so we took Henry back. The ride was too much. He died in the hearse before we got home.

NARRATOR: Thank you, Mrs. Willis.

2ND NARRATOR: The disease that took your husband, Mrs. Willis, need not kill if discovered in time. If in every state, cancer centers were built and equipped; cancer centers in each state where anyone, rich or poor, could be assured of treatment . . .

MRS. FOSTER: How well I know that!

NARRATOR: Why, hello, Mrs. Foster. Glad you could come. I wish you'd tell your story.

MRS. FOSTER: When I discovered the lump in my breast, I went right to the New York State Tumor Clinic in Buffalo which was only 20 miles away. They told me it was cancer. They told me I came in plenty of time. They said radium. I had no money for radium, but they gave it to me free of charge. For two years I kept coming back for treatments and I'm all right now. There's no reason why everybody shouldn't have a place like that to go to in every state in the Union.

2ND NARRATOR: Thank you, Mrs. Foster.

NARRATOR: Suppose we listen to what the National Resources Planning Board has to tell us:

VOICE: "Preventive health services for the nation as a whole are insufficient. Hospital and other institutional facilities are inadequate in many communities, especially in rural areas. Financial support for hospital care and professional services are not enough, particularly for people of the lower income groups."

JOE: Let's see if I get this straight—there are too many places in this country that haven't hospitals close by and should have them?

NARRATOR: Every year, Joe, cancer and heart disease are the two principal causes of death. Since we need all the man power we can muster in times like these, should we not prevent many of these deaths through adequate hospitals and clinics open for rich and poor alike?

2ND NARRATOR: And that's only the first problem, Joe. Here is the second:

VOICE: Each year about 14,000 women die from causes connected with pregnancy and childbirth.

JOE: Say, that's fierce!

THOMAS: (He is very young and hesitant) Yes, it is.

NARRATOR: Glad you could come to tell us your story, Mr. Thomas.

THOMAS: It was to be our first baby. My wife was only twenty. The only doctor in the neighborhood was up in the city for a visit. We didn't have any midwife and for seventy-two hours she was in agony.

NARRATOR: Where was the nearest hospital?

THOMAS: Thirty miles away. You see we lived on a farm. Seventy-two hours she kept screaming—three days of labor pains. We wrapped her in blankets, put her in the car and drove to the hospital. But she died on the table. The hospital doctor told me she could have had her child and been happy. He was a fine doctor. He said every year thousands of mothers die. He called it a crime. He said one-half to two-thirds of these deaths could be prevented.

JOE: How?

NARRATOR: Dr. Martha Eliot, Assistant Chief of the Children's Bureau in the Department of Labor, has said:

ELIOT: "There must be facilities that provide for prenatal care of mothers; medical care of mothers and their newborn infants; care given by qualified local physicians with the aid of specialized consultants; assisted by nurses, preferably public health nurses, trained in obstetric nursing procedure. There must be facilities for expert diagnosis and care in diagnostic or consulation centers and in the home—*for any mother, regardless of economics.*"

DOCTOR: We know that's true. Mothers don't have to die.

NARRATOR: I'm glad you came, Dr. Lindley. Will you tell the folks who you are."

DOCTOR: I'm a physician living in Cattaraugus County in the State of New York. Every day in Cattaraugus County, with the cooperation of the County Medical Society, the Milbank Memorial Fund and funds from the Social Security Act, a mother in or near the town of Orleans, regardless of whether or not she can afford private care, is given a thorough prenatal examination. We follow this examination up with monthly check-ups. The baby is delivered by a doctor assisted by a nurse. He watches for all symptoms of blood poisoning, convulsions and hemorrhage. There is no reason why maternity centers for the needy and for rural areas should not be flowering all over the United States.

NARRATOR: Thank you, Doctor.

2ND NARRATOR: The third problem, Joe, is:

VOICE: Industrial diseases and hazards . . .

NARRATOR: We're going to need all the workers we can get in the factories, in the mills and the plants—to make tools, machinery, planes, tanks, ammunition. Hard dangerous work that needs stamina and needs health.

STEVE: (Hard-Bitten, Young and Intelligent) I'll tell the cockeyed world . . .

2ND NARRATOR: Glad you could come here, Steve.

NARRATOR: You can explain the problem as well as anybody.

STEVE: You bet I can. There were four of us brothers. Not one of us weighed less than 180. I worked in the coal mines in West Virginia; Gus worked in a factory in Ohio, Pete was a swing grinder in a steel mill; Ed worked in the stockyards.

JOE: What happened?

STEVE: Pete was the kid brother—him in the steel mill—he sweated because the furnaces were hot and then he'd come out in the cold when it was winter and he got pneumonia. So he died. Ed, that was my older brother,—him in the stockyards—he gets hog itch—he was laid up for months. Gus—worked on a machine and he knows something is wrong with it. One day the thing goes to pieces, caves his chest in—he dies. Me—the last week I began to spit blood and started coughing—the doc says I got silicosis. Well, two of us are dead and Ed and me might just as well be—we ain't no good. And we could have taken on double our weight in any fight.

JOE: Why did it happen!

STEVE: It didn't have to. You got more than fifteen million people working in plants and fac-

tories. The less sickness they have and the less chance of accidents the better off this country will be for defense. After all we're the guys that make things run. So what's to be done? So this has got to be done. Educate the workers—the unskilled workers. Teach them to be careful. There ought to be more guys to keep their eyes on workers and train them not to have accidents. There ought to be more laws, laws to keep the factories and the mines safe. There ought to be closer inspection and better cooperation between the state inspectors and employers. And what's most needed is medical care for all the workers—quick care—good care—So a guy like me don't have to run around in circles coughing his lungs out until he gets a doctor.

2ND NARRATOR: Thank you, Steve. .. ..

NARRATOR: Now do you see, Joe, how all these little pieces fit together to tell a serious story? Do you see this waste of human life?

2ND NARRATOR: And we're not through. Here's the most important problem of them all.

NARRATOR: Medical care for the medical needy.

WOMAN: (Young, Tired, Bewildered) Yeah...

2ND NARRATOR: Glad you came, Mrs. Kolokowski. Let's hear your story.

MRS. K.: I'm twenty-five. Lou works on a construction gang. We pay $16 a month for the flat.

NARRATOR: You have children?

MRS. K.: One baby, two years old.

2ND NARRATOR: Where is he?

MRS. K.: In the country . . . he's been sick.

JOE: What's the matter with him?

MRS. K.: The doctor at the clinic said he must go to the Children's Home in the country. The doctor said he had a heart murmur.

NARRATOR: Had he been sick before?

MRS. K.: Five months ago he had a bad ear. He got over that and then he got scarlet fever. We had to send him to the hospital. And he had to stay three weeks more because he got chicken pox. Then he got this heart murmur. If I'd felt well I could have taken better care of the baby maybe.

2ND NARRATOR: You have been sick?

MRS. K.: When the baby came I went to the clinic. They found out I had a touch of t.b. They said I should rest. You ask my husband if I can rest.

MR. K.: (Young and Bewildered) Hello.

NARRATOR: Can't your wife rest up?

MR. K.: Fat chance; I don't know how I'm going to keep on. I owe money. Medicine costs a lot. I got two hundred dollars I got to pay to doctors. God knows where I'll get it.

JOE: How do *you* feel, brother?

MR. K.: Me? I can't afford to get sick. I got to work. Getting sick takes every penny. It's sure funny how much we get sick. Maybe it's the flat. No sun, no ventilation. Maybe because we've always been poor and never had any doctors when were kids. I don't get it. I don't know why our baby's got a heart murmur, anymore than why the wife's got t.b. Funny, ain't it?

NARRATOR: (Sarcastically) Funny, ain't it, Joe?

JOE: No, there's nothing funny about that! The way I see it we're just letting large hunks of our population get sick and die when they might be healthy and alive! Especially now when everybody is needed to put his shoulder to the wheel!

NARRATOR: Yes, Joe. We spend huge fortunes constructing highways, but not enough to take care of our mothers and our children. We spend millions in soil conservation, but what about human conservation? Listen to what the National Resources Planning Board writes:

VOICE: One-third of the nation, those with incomes under $750 a year, is receiving inadequate or no medical service at all. An even larger section of the population suffers from economic burdens created by illness. Among those with low incomes there is more sickness and death, as a result of less healthful living conditions.

2ND NARRATOR: The time has come, Joe, when we must remember that we've got to step up our rate of progress in health. The phrase is "life, liberty and the pursuit of happiness"—the liberty and the pursuit of happiness of the nation aren't enjoyed less the life of the nation is sound and healthy.

JOE: Well, we've got a job ahead of us! What's to be done?

NARRATOR: Here's what's to be done, Joe.

2ND NARRATOR: There must be a national defense health plan conceived and planned in cooperation with all the people of the United States. This is a democracy. Let the *people* wake up to the fact that health is as important a problem in total defense as building a battleship.

VOICE: Work must be done on slum clearance and housing and adequate relief for all the people . . .

2ND VOICE: There must be enough hospitals and medical care for all people regardless of income . . .

3RD VOICE: There must be a stepping up in our national drive against syphilis, tuberculosis and cancer.

4TH VOICE: In this national defense health plan all pre-school and school age children must be vaccinated against smallpox, whooping cough and diphtheria.

VOICE: There must be expanded clinic and hospital service for prenatal care, for delivery, and for postnatal care.

2ND VOICE: Enforcement of present laws to do away with occupational diseases and hazards, better factory inspection, and a drive to educate workers to protect themselves from accidents.

3RD VOICE: An education program which can reach every one of 132 million people and teach them the importance of reaching a Doctor at the first sign of illness.

JOE: Are these things being done?

NARRATOR: Too many of us are expecting miracles to happen overnight because of defense. You can't build a battleship in a month nor can you make progress in national health in a few weeks.

2ND NARRATOR: But we are beginning strongly. Harriet Elliott of the Defense Commission has already begun work on these problems. She has five authorities as advisers on nutrition, on prices of food, on public health, on housing. A few weeks ago a meeting was held in Washington at which you, the People, sent your Delegates to represent you. These Delegates were from all walks of life; they represented trade unions, schools, nursing bureaus, farmers, and industrial workers. They sat for hours and made suggestions to the Defense Commission as to what to do. Here's what they suggested:

VOICE: Low labor standards threaten efficiency!

2ND VOICE: Low levels of health and nutrition menace the vigor of our people!

3RD VOICE: Exclusions and prejudices menace national unity!

4TH VOICE: Low living standards and lack of understanding and participation in democracy menace democratic values!

NARRATOR: And, Joe, there are recommendations that will help to start things going. They're going to work for more vigorous local ordinances for housing, health and sanitation and for enforcing such ordinances. Relief authorities are being asked to set housing standards for families on relief. Local medical societies are being urged to study medical services locally to determine the best distribution between civilian and military requirements. They want to make sure civilian needs in the community will be taken care of.

JOE: Well, that sounds pretty good to me.

NARRATOR: Yes, Joe, it shows the ability of democracy to take a problem in which we are all concerned and to solve that problem—not for the *few* but for every individual among us . . .

JOE: It looks as though the people can help in most of this work.

NARRATOR: It will have to be that way, or it will fail. If the people of this country wake up and realize how important their health is to total defense, they will do something about it. It needs education. It needs organization. It needs money. We have got to stop wasting human life! And with your help, Joe, we'll do it!

MUSIC: UP AND OUT.

MISCELLANEOUS

Industrial Physicians and Employers to Convene November 14

Industrial physicians and manufacturers from all over the country will attend the American Conference on Industrial Health to be held Thursday, November 14, at the Towers Club in Chicago. The conference will be sponsored by the American Association of Industrial physicians and Surgeons.

This first meeting of the American Conference on Industrial Health has for its purpose the correlation of viewpoints of all persons who are interested in promoting industrial health. These include the employer, physician, industrial hygienist, labor, psychiatrist, insurance companies, public relations men, safety expert, and the legal profession.

Dr. Clarence O. Sappington of Chicago, well-known consulting industrial hygienist, and co-chairman of the committee with Dr. Edward C. Holmblad, stated: "We have invited the manufacturer and other persons to attend and participate in the convention so that we may prove the practical value and application of industrial health work, and so that they may realize how much time and money may be saved yearly by such measures."

Among the prominent speakers who will talk at the convention sessions are: Dr. Morris Fishbein, editor of the American Medical Association Journal; Mr. B. C. Heacock, president of the Caterpillar Tractor Company of Peoria; Dr. Volney S. Cheney, medical director of Armour and Company; and J. M. Conway, representing the National Association of Manufacturers, New York.

The conference, which is scheduled to begin at 9:30 a. m., will conclude with a dinner session at which Dr. Fishbein and Mr. Conway will speak.

Applications Closed for Army

The Civil Service Commission announces that enough applications have been received to meet the prospective need for temporary and part-time civilian medical officers in connection with the Army expansion. Receipt of applications closed October 14.

The Commission calls attention to the fact, however, that there is an urgent need for medical officers and senior and associate medical officers to fill permanent positions in other agencies. Applications will be received until further notice. The positions pay from $3,200 to $4,600 a year. Fourteen specialized branches of medicine are included.

There is also an urgent need to fill junior medical officer positions at $2,000 a year at St. Elizabeth's Hospital, Washington, D. C.

Full information and application form for these examinations may be obtained at the office of the Secretary, Board of U. S. Civil Service Examiners at any first or second-class post office, or from the U. S. Civil Service Commission, Washington, D. C., or from any of the Commission's district offices.

BOOK REVIEWS

A Textbook of Medicine. By American Authors. Edited by Russell L. Cecil, M. D., Professor of Clinical Medicine, Cornell University; and Foster Kennedy, M. D., Professor of Clinical Neurology, Cornell University. Fifth Edition. Pp. 1744, with 173 illustrations. Cloth. Price, $9.50. Philadelphia: W. B. Saunders Company, 1940.

The several authors responsible for this volume have again produced an outstanding textbook and reference work, for clinicians and students alike. It may be considered an authoritative cross section of present-day American medicine, and is as up-to-the-minute as the writing of a textbook permits. Several chapters have been added and many rewritten.

This reviewer feels that the present status of the vitamins and their interrelationship might have been more adequately discussed.

The authors and publishers are to be commended in keeping the material in one volume of convenient size, although it is regrettable that a work of this calibre could not be printed upon less translucent paper, and thus avoid annoying show-through. Undoubtedly this edition will be received with the same enthusiasm as has greeted the other four.

Physical Diagnosis. By Ralph H. Major, M. D., Professor of Medicine, University of Kansas. Second Edition. Pp. 464, with 437 illustrations. Cloth. Price, $5.00. Philadelphia: W. B. Saunders Company, 1940.

Here is a concise treatise on physical diagnosis, logically arranged and pleasingly presented. The proper approach to the physical examination of individual organs or sections of the body is followed by the signs which may be found in specific diseases.

The material is correctly limited to actual physical diagnosis, no attempt being made to include laboratory findings, or to discuss in detail those subjects which are special studies in themselves.

Frequent historical facts and quotations from the earlier masters are stimulating and interesting. The photographs of patients unfortunately reveal markedly advanced pathology. However, this may serve to fix in the reader's mind the distinguishing feature of the various pathological conditions.

The work is recommended to clinicians as well as students.

Management of the Cardiac Patient. By William G. Leaman, Jr., M. D., Assistant Professor of Medicine in Charge of the Department of Cardiology, Woman's Medical College of Pennsylvania. Pp. 705, with 255 illustrations. Cloth. Price, $6.50. Philadelphia: J. B. Lippincott Company, 1940.

Too often the contents of a book do not fulfill the expectations aroused by the title. This one does. All phases of the management of the cardiac patient are thoroughly discussed. Drug therapy, particularly, is covered in gratifying detail. Many case reports, accompanied by photographs and sketches and frequently by electrocardiograms, anticipate practically any situation with which the practitioner may be confronted. Several of these case reports are discussed by other authors. The chapter devoted to electrocardiography begins at the beginning and admirably outlines the subject. Truly a book for the general practitioner, both the author and the publishers are to be commended for its excellence.

Psychiatry for Nurses. By Louis J. Karnosh, M. D., Associate Clinical Professor of Nervous Diseases, Western Reserve University; and Edith B. Gage, R. N., Supervisor, Neuropsychiatric Division, City Hospital, Cleveland. Pp. 327, with 34 illustrations. Cloth. Price, $2.75. St. Louis: C. V. Mosby Company, 1940.

This book is an excellent text for the undergraduate nurses. The authors have refrained from spending too much time on theory, thus avoiding confusion in the student's mind. Yet this subject is not neglected and is presented in a manner in which the interested student is stimulated. The etiology and symptomatology of the various psychoses are clearly and concisely handled. The book is readily understood and does not make the subject of psychiatry a tedious burden. It can be well recommended as a text.

Gynecological and Obstetrical Pathology. By Emil Novak, M. D., Associate in Gynecology, Johns Hopkins University School of Medicine. Pp. 496, with 427 illustrations. Cloth. Price $7.50. Philadelphia: W. B. Saunders Company, 1940.

This book, like all writings by Dr. Novak, is delightful reading. He has the unusual ability of expressing himself so clearly that he leaves no doubts in one's mind as to what he means. He takes up the pathology of the various tissues and organs in a logical order. The text is very well illustrated with microscopic sections, which are not colored, but so well prepared that the pathology is well depicted. Illustrations of gross pathology are not so plentiful.

The chapter on histology of the endometrium is especially interesting. In this chapter he explains the present concept of hormonal influences on the endometrium, as well as histologic changes produced by pregnancy.

The book is quite comprehensive, and we heartily recommend it.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC.

Required by the Act of Congress of August 24, 1912 of the Delaware State Medical Journal, Published Monthly at Wilmington, Delaware, for October 1st, 1940.

STATE OF DELAWARE } SS.
COUNTY OF NEW CASTLE }

Before me, a Notary Public in and for the State and County aforesaid, personally appeared M. A. Tarumianz, M. D., who having been duly sworn according to law, deposes and says that he is the Business Manager and Associate Editor of the Delaware State Medical Journal, and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper, the circulation), etc. of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, embodied in section 411, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are:

Name of— Post Office Address

Publisher, Medical Society of Delaware, Wilmington, Delaware.

Editor, W. Edwin Bird, M. D., duPont Bldg., Wilmington, Del.

Associate Managing Editors—M. A. Tarumianz, M. D., Farnhurst, Del., and C. L. Munson, M. D., 1015 Washington St., Wilmington, Del.

Business Manager, M. A. Tarumianz, M. D., Farnhurst, Del.

2. That the owner is: (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding one per cent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a firm, company, or other unincorporated concern, its name and address, as well as those of each individual member, must be given.)

The Medical Society of Delaware.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages or other securities are: (If there are none, so state): None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company, but also in cases where stockholder or security holder appears upon the books of the company as trustees or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stocks, bonds or other securities than as so stated by him.

M. A. TARUMIANZ, M. D.
Business Manager

Sworn and subscribed to before me this 28th day of September, 1940.

JULIA A. TWOMEY.
Notary Public
(My commission expires March 14, 1941)

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